NOTICES OF EXEMPT RULEMAKING

The Administrative Procedure Act requires the *Register* publication of the rules adopted by the state's agencies under an exemption from all or part of the Administrative Procedure Act. Some of these rules are exempted by A.R.S. §§ 41-1005 or 41-1057; other rules are exempted by other statutes; rules of the Corporation Commission are exempt from Attorney General review pursuant to a court decision as determined by the Corporation Commission.

NOTICE OF EXEMPT RULEMAKING

9. HEALTH SERVICES

CHAPTER 30. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PREMIUM SHARING PROGRAM

PREAMBLE

1.	**Sections Affected**	**Rulemaking Action**
	R9-30-101	Amend
	R9-30-103	Amend
	R9-30-106	Amend
	R9-30-107	Amend
	R9-30-201	Amend
	R9-30-205	Amend
	R9-30-206	Amend
	R9-30-207	Amend
	R9-30-211	Amend
	R9-30-212	Amend
	R9-30-213	Amend
	R9-30-301	Amend
	R9-30-302	Amend
	R9-30-303	Amend
	R9-30-304	Amend
	R9-30-305	Amend
	R9-30-306	Amend
	R9-30-401	Repeal
	R9-30-403	Repeal
	R9-30-404	Repeal
	R9-30-405	Repeal
	R9-30-406	Repeal
	R9-30-407	Repeal
	R9-30-408	Repeal
	R9-30-409	Repeal
	R9-30-501	Amend
	R9-30-507	Amend
	R9-30-509	Amend
	R9-30-511	Amend
	R9-30-512	Amend
	R9-30-513	Amend
	R9-30-514	Amend
	R9-30-520	Amend
	R9-30-521	Amend
	R9-30-522	Amend
	R9-30-523	Amend
	R9-30-601	Amend
	R9-30-602	Amend
	R9-30-603	Amend
	R9-30-701	Amend
	R9-30-702	Amend
	R9-30-703	Amend
	R9-30-807	Amend
	R9-30-901	New Section

R9-30-902	New Section
R9-30-903	New Section

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 36-2903 and 36-2903.01

Implementing statutes: A.R.S. §§ 36-2903 and 36-2903.01

3. The effective date of the rules:

October 1, 2002

4. A list of all previous notices appearing in the Register addressing the exempt rule:

Notice of Public Meeting on Open Rulemaking Docket: 8 A.A.R. 3137, July 26, 2002

Notice of Rulemaking Docket Opening: 8 A.A.R. 3134, July 26, 2002

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name:	Claire Sinay, Federal and State Policy Manager
Address:	AHCCCS Office of Policy Analysis and Coordination 801 E. Jefferson, Mail Drop 4200 Phoenix, AZ 85034
Telephone:	(602) 417-4178
Fax:	(602) 256-6756

6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:

Laws 2002, Ch. 329, § 35 exempts the Administration from rulemaking requirements of A.R.S. Title 41, Chapter 6 for the purposes of implementing the Premium Sharing Program (PSP). The Administration amended all Articles in 9 A.A.C. 30 to comply with recent changes to the PSP by Laws 2002, Ch. 329, §§ 36-2903 and 36-2903.1.

7. A reference to any study relevant to the rule that the agency reviewed and either proposes to rely on in its evaluation of or justification for the rule or proposes not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

None

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

Not applicable

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

Not applicable

11. A summary of the principal comments and the agency response to them:

AHCCCS received one letter, but it was received after the closing of the public comment period.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

13. Incorporations by reference and their location in the rules:

None

14. Was this rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

9. HEALTH SERVICES

CHAPTER 30. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PREMIUM SHARING PROGRAM

ARTICLE 1. DEFINITIONS

Section
R9-30-101. Location of Definitions
R9-30-103. Eligibility and Enrollment Related Definitions
R9-30-106. Grievance and Request for Hearing Related Definitions
R9-30-107. Payment Responsibilities Related Definitions

ARTICLE 2. SCOPE OF SERVICES

Section
R9-30-201. General Requirements
R9-30-205. Primary Care Provider Services
R9-30-206. Organ and Tissue Transplantation Services
R9-30-207. Dental Services
R9-30-211. Transportation Services
R9-30-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices
R9-30-213. ~~Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT)~~ Health Risk Assessment and Screening Services

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

Section
R9-30-301. General Requirements
R9-30-302. Time-frames for Determining Eligibility
R9-30-303. Conditions of Eligibility
R9-30-304. Enrollment
R9-30-305. Disenrollment
R9-30-306. Redetermination

ARTICLE 4. ~~CONTRACTS~~ REPEALED

Section
R9-30-401. ~~General Provisions~~ Repealed
R9-30-403. ~~PSA's Contracts with Contractors~~ Repealed
R9-30-404. ~~Subcontracts~~ Repealed
R9-30-405. ~~Contract Records~~ Repealed
R9-30-406. ~~Mergers; Reorganizations; Change in Ownership; and Contract Amendments~~ Repealed
R9-30-407. ~~Suspension, Modification, or Termination of Contract~~ Repealed
R9-30-408. ~~Contract Compliance Sanction Alternative~~ Repealed
R9-30-409. ~~Contract or Protest; Request for Hearing~~ Repealed

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

Section
R9-30-501. General Authority
R9-30-507. Member Record
R9-30-509. Transition and Coordination of Member Care
R9-30-511. Fraud and Abuse
R9-30-512. Release of Safeguarded Information by the PSA and a Contractor
R9-30-513. Discrimination Prohibition
R9-30-514. Equal Opportunity
R9-30-520. Financial Statements, Periodic Reports, and Information
R9-30-521. Program Compliance Audits
R9-30-522. Quality Management/Utilization Management (QM/UM) Requirements
R9-30-523. Financial Resources

ARTICLE 6. GRIEVANCE AND REQUEST FOR HEARING

Section
R9-30-601. General Provisions for a Grievance and a Request for Hearing
R9-30-602. Grievance
R9-30-603. Eligibility Hearing for an Applicant and a Member

ARTICLE 7. PAYMENT RESPONSIBILITIES

Section
R9-30-701. A Member's Payment Responsibilities
R9-30-702. The ~~PSA's~~ Administration's Scope of Liability: The ~~PSA's~~ Administration's Payment Responsibility to Contractors
R9-30-703. Contractor's and Provider's Claims and Payment Responsibilities

ARTICLE 8. MEMBERS' RIGHTS AND RESPONSIBILITIES FOR EXPEDITED HEARINGS

Section
R9-30-807. Expedited Hearing Process

ARTICLE 9. CONTRACT PROCESS

Section
R9-30-901. General Provisions
R9-30-902. Contract Compliance Sanction
R9-30-903. Contract Protest; Grievance and Request for Hearing

ARTICLE 1. DEFINITIONS

R9-30-101. Location of Definitions

A. Location of definitions. Definitions applicable to Chapter 30 are found in the following:

Definition	Section or Citation
"Abuse"	R9-30-101
"AHCCCS"	R9-22-101
"Administration"	A.R.S. § 36-2901
"Ambulance"	~~R9-22-102~~ A.R.S. § 36-2201
"Applicant"	R9-30-101
"Chronic disease"	R9-30-102
"Chronically ill member"	R9-30-102
"Clean claim"	A.R.S. § 36-2904
"Contract year"	R9-30-101
"Contractor"	~~R9-22-101~~ A.R.S. § 36-2901
"Copayment"	R9-30-107
"Covered services"	R9-30-102
"Date of application"	R9-30-103
"Date of notice"	R9-22-108
"Day"	R9-22-101
"Eligible for AHCCCS benefits"	R9-30-103
"Eligible household member"	R9-30-101
"Emergency medical services"	R9-22-102
"Enrollment"	R9-30-103
~~"E.P.S.D.T. services"~~	~~R9-22-102~~
"FPL"	R9-30-103
"Fund"	A.R.S. § 36-2923
"Grievance"	R9-22-108
"Head-of-household"	R9-30-103
"Health History Questionnaire"	R9-30-101

"Hearing"	R9-22-108
"Hospital"	R9-22-101
"Household income"	R9-30-103
"Household unit"	R9-30-103
"Inpatient hospital services"	R9-30-101
"Life threatening"	R9-27-102
"Medical record"	R9-22-101
"Medical services"	~~R9-22-101~~ A.R.S. § 36-401
"Medically necessary"	R9-22-101
"Member"	~~R9-30-103~~ A.R.S. § 36-2901
"Month of application"	R9-30-103
"Noncontracting provider"	~~A.R.S. § 36-2931~~ A.R.S. § 36-2901
"Offeror"	R9-22-106
"Other health care practitioner"	R9-27-101
"Outpatient hospital services"	R9-22-107
"Pharmaceutical services"	R9-22-102
"Practitioner"	R9-22-102
"Premium"	R9-30-107
"Premium Share"	R9-30-107
"Pre-payment"	R9-30-107
"Prescription"	R9-22-102
"Primary care provider"	R9-22-102
"Prior authorization"	R9-22-102
"Providers"	A.R.S. § 36-2901
~~"PSA"~~	~~R9-30-101~~
"PSP"	R9-30-101
"Quality management"	R9-22-105
"Redetermination"	R9-30-103
"Referral"	R9-22-101
"Respondent"	R9-22-108
"RFP"	~~R9-22-105~~ R9-22-106
"Service area"	R9-30-103
"Scope of services"	R9-22-101
"Subcontract"	R9-22-101
"System"	A.R.S. § 36-2901
"Utilization management"	R9-22-105

B. General definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.

"Abuse" means the inappropriate chronic, habitual, or compulsive use of any chemical matter that, when introduced into the body, in any way, is capable of causing altered human behavior or altered mental functioning and which, if used over an extended period of time, may cause psychological or physiologic dependence or impairment.

"Applicant" means a person who submits, or on whose behalf is submitted, a signed and dated application for enrollment in the PSP.

"Contract year" means October 1 through September 30.

"Eligible household member" means a person in a household unit that is eligible for PSP coverage under this Chapter.

"Health History Questionnaire" means a form that is required to be completed by each person in the household, prior to enrollment that is submitted with the initial premium payment, that indicates any previously treated condition, or disease, or medication received by the person.

"Inpatient hospital services" means medically necessary services that require an inpatient stay in an acute hospital. Inpatient hospital services are provided by or under the direction of a primary care provider or other health care practitioner upon referral from a member's primary care provider.

~~"PSA" means the Premium Sharing Administration, which is the entity designated by the AHCCCS Director to carry out the administrative functions of the PSP under A.R.S. § 36-2923.01.~~

"PSP" means Premium Sharing Program ~~under A.R.S. § 36-2923.01~~.

R9-30-103. Eligibility and Enrollment Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.

"Date of application" means the date a signed and dated PSP application is received in the ~~PSA~~ Administration office.

"Eligible for AHCCCS benefits" means enrolled as a member of the Arizona Health Care Cost Containment System, beginning the first day of the month following the date a person has been determined eligible under ~~A.R.S. 36-2901(4).~~ A.R.S. § 36-2901(6).

"Enrollment" means the process by which a person applies for coverage, is determined eligible, selects a PSP contractor, and begins making full premium payments to the ~~PSA~~ Administration.

"FPL" means the federal poverty level, the federal poverty guidelines published annually by the United States Department of Health and Human Services.

"Head-of-household" means the household member who assumes the responsibility for providing PSP eligibility information for the household unit in accordance with Article 3 of this Chapter. The head-of-household may designate a nonhousehold member as the household's representative.

"Household income" means the total gross amount of all money received by all eligible or ineligible household members such as cash, a check, a cashier's check, a money order, or as a deposit into the household member's solely or jointly owned financial account.

"Household unit" means one or more persons who reside together in a household and are considered in determining eligibility.

~~"Member" means an enrollee as defined under A.R.S. § 36-2923.01.~~

"Month of application" means the calendar month during which a signed and dated PSP application is postmarked if mailed or, if hand-delivered, the date of actual delivery.

"Redetermination" means the periodic submission of a PSP redetermination form by a current member requesting continuation of PSP coverage, and the review of that application and determination of ongoing eligibility and premium by the ~~PSA~~ Administration.

"Service area" means the area for which a contractor has contracted with ~~AHCCCS~~ the Administration to provide services to members.

R9-30-106. Grievance and Request for Hearing Related Definitions

~~Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning:~~

~~"Date of notice" is defined in 9 A.A.C. 22, Article 1.~~

~~"Grievance" is defined in 9 A.A.C. 22, Article 1.~~

~~"Hearing" is defined in 9 A.A.C. 22, Article 1.~~

~~"Respondent" is defined in 9 A.A.C. 22, Article 1.~~

Definitions. The words and phrases in this Chapter have the same meaning as specified in 9 A.A.C. 22, Article 1 unless the context of the Chapter explicitly requires another meaning.

R9-30-107. Payment Responsibilities Related Definitions

Definitions. The words and phrases in this Chapter have the following meanings unless the context of the Chapter explicitly requires another meaning.

"Copayment" means a monetary amount a member pays directly to a provider at the time covered service is rendered.

"Premium" means the total amount due monthly for the provision of covered services to members.

"Premium share" means the portion of the premium, not to exceed 6 percent of the member's gross annual household income, a member whose household income is equal to or less than ~~250~~ 200 percent of FPL must pay monthly under A.R.S. § 36-2923.01 for the provision of covered services.

"Pre-payment" means submission of the household's share of the premium. The prepayment is due 30 days before the ~~effective date~~ month of coverage.

ARTICLE 2. SCOPE OF SERVICES

R9-30-201. General Requirements

A. In addition to the requirements and limitations specified in this Chapter, the following general requirements apply:
1. Covered services provided to a member shall be medically necessary and provided by or under the direction of a primary care provider or dentist; specialist services shall be provided under referral from and in consultation with the primary care provider.
   a. The role or responsibility of a primary care provider, as defined in these rules, shall not be diminished by the primary care provider delegating the provision of primary care for a member to a practitioner.
   b. Behavioral health screening and evaluation services may be provided without referral from a primary care provider. Behavioral health treatment services shall be provided only under referral from, and in consultation with, the primary care provider, or upon authorization by the contractor or its designee.
   c. The contractor may waive the referral requirements.
2. Behavioral health services are limited to 30 days of inpatient care and 30 outpatient visits per contract year under Laws 2001, Ch. 385, § 13.
3. Services shall be rendered in accordance with state laws and regulations, the Arizona Administrative Code, and ~~PSA~~ the Administration's contractual requirements.
4. Experimental services as determined by the Director or services provided primarily for the purpose of research shall not be covered.
5. PSP services shall be limited to those services that are not covered for a member who is covered by another funding source as specified in ~~R9-30-301~~ A.R.S. § 36-2923.01.
6. Services or items, if furnished gratuitously, are not covered. ~~and payment shall be denied.~~
7. Personal care items are not covered. ~~and payment shall be denied.~~
8. Medical or behavioral health services shall not be covered if provided to:
   a. An inmate of a public institution;
   b. A person who is in an institution for the treatment of tuberculosis; or
   c. A person who is in an institution for the treatment of a mental disorder, unless provided under this Article.

B. The ~~PSA~~ Administration ~~may~~ shall require that providers be AHCCCS registered. Services ~~may~~ shall be provided by AHCCCS registered personnel or facilities that meet state requirements and are appropriately licensed or certified to provide the services.

C. Payment for services or items requiring prior authorization may be denied if prior authorization is not obtained from the contractor. Emergency services as defined in A.A.C. R9-22-102 do not require prior authorization; however, the member shall notify the contractor as required in R9-30-210.
1. The contractor shall prior authorize services for a member based on the diagnosis, complexity of procedures, and prognosis, and be commensurate with the diagnostic and treatment procedures requested by the member's primary care provider or dentist.
2. Services for unrelated conditions requiring additional diagnostic and treatment procedures require additional prior authorization.
~~3. In addition to the requirements of Article 7 of this Chapter, written documentation of diagnosis and treatment may be required for reimbursement for services that require prior authorization.~~
3. The Administration or contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. Documentation of diagnosis and treatment is required for reimbursement of services that require prior authorization.

D. A covered service rendered to a member shall be provided within the service area of the member's contractor except when:
1. A primary care provider refers a member out of the contractor's area for medical specialty care;
2. A covered service that is medically necessary for a member is not available within the contractor's service area;
3. A net savings in service delivery costs can be documented without requiring undue travel time or hardship for a member or the member's household;
4. A member is placed in a nursing facility located out of the contractor's service area with contractor approval;
5. The service is otherwise authorized by the contractor based on medical practice patterns, and cost or scope of service considerations; or
6. The service is an emergency service as defined in R9-30-210.

E. When a member is traveling or temporarily outside of the service area of the member's contractor, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.

F. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in these rules and in contract.

G. The Director shall determine the circumstances under which a member may receive services, other than emergency services as specified in subsection (E), from service providers outside the contractor's service area or outside the state. Criteria considered by the Director in making this determination shall include availability, accessibility of appropriate care, and cost effectiveness.

H. If a member is referred out of the contractor's service area to receive an authorized medically necessary service for an extended period of time, the contractor shall also provide all other medically necessary covered services prior authorized by the contractor for the member during that time.

I. The restrictions, limitations, and exclusions in this Article shall not apply to the costs associated with providing any noncovered service to a member and shall not be included in development or negotiation of capitation.

J. Under A.R.S. § 36-2907 the Director may, upon 30 days advance written notice to contractors, modify the list of services for all members.

K. A contractor may withhold nonemergency medical services to a member who does not pay a copayment in full at time the service is rendered under A.R.S. § 36-2923.01.

R9-30-205. Primary Care Provider Services

A. Primary care provider services shall be furnished by a physician or practitioner and shall be covered for a member when rendered within the provider's scope of practice under A.R.S. Title 32. Primary care provider services may be provided in an inpatient or outpatient setting and shall include at a minimum:
1. Periodic health examinations and assessments,
2. Evaluations and diagnostic workups,
3. Medically necessary treatment,
4. Prescriptions for medications and medically necessary supplies and equipment,
5. Referrals to specialists or other health care professionals when medically necessary,
6. Patient education,
7. Home visits when determined medically necessary,
8. Covered immunizations, and
9. Covered preventive health services.

B. The following limitations and exclusions apply to primary care provider services:
1. Specialty care and other services provided to a member upon referral from a primary care provider shall be limited to the services or conditions for which the referral is made, or for which authorization is given, unless referral is waived by the contractor;
2. If a physical examination is performed with the primary intent to accomplish one or more of the objectives listed in subsection (A), it shall be covered by the member's contractor, except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:
   a. Qualification for insurance;
   b. Pre-employment physical evaluation;
   c. Qualification for sports or physical exercise activities;
   d. Pilot's examination (FAA);
   e. Disability certification for establishing any kind of periodic payments;
   f. Evaluation for establishing ~~3rd-party~~ third-party liabilities; or
   g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A);
3. Orthognathic surgery shall be covered only for a member who is less than ~~21~~ 18 years of age; and
4. The following services shall be excluded from PSP coverage:
   a. Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;
   b. ~~Abortion~~ Pregnancy termination counseling services;
   c. ~~Abortions~~ Pregnancy termination, unless authorized under state law, as specified in ~~A.R.S. § 36-2903.01~~ A.R.S. § 35-196.02;
   d. Services or items furnished solely for cosmetic purposes;
   e. Hysterectomies unless determined to be medically necessary;
   f. Elective surgeries with the exception of voluntary sterilization procedures; and
   g. Except for breast reconstruction performed by a contracted contractor following a mastectomy under R9-30-215, services or items provided to reconstruct or improve personal appearance after an illness or injury.

R9-30-206. Organ and Tissue Transplantation Services

A. A member is eligible for the following organ transplantation services under A.R.S. § 36-2923.01 if prior authorized and coordinated with the member's contractor:
1. Kidney transplantation,
2. Cornea transplantation, and

3. Immunosuppressant medications and other related services including medically necessary dental services required prior to and associated with a kidney or cornea transplant.

B. In addition to a transplantation service in subsection (A), a member who has a chronic illness under ~~Laws 2001, Ch. 385, § 14~~ A.R.S. § 36-2923.01 is eligible for the following organ and tissue transplantation services as specified in A.R.S. § 36-2907 if prior authorized and coordinated with the member's contractor:
1. Heart transplantation;
2. Liver transplantation;
3. Autologous and allogeneic bone marrow transplantation;
4. Lung transplantation;
5. Heart-lung transplantation;
6. Other organ transplantation if the transplantation is required by A.R.S. § 36-2907, and if other statutory criteria are met; and
7. Immunosuppressant medications, chemotherapy, and other related services including medically necessary dental services required prior to and associated with a transplant.

C. Artificial or mechanical hearts and xenografts are not covered services for organ and tissue transplantation services.

R9-30-207. Dental Services

A. ~~Emergency dental care, which encompasses the following services, shall be covered:~~ A contractor shall cover the following emergency dental care services:
1. Emergency oral diagnostic examination including laboratory and radiographs when necessary to determine an emergent condition;
2. Immediate palliative treatment, including extractions when professionally indicated, for relief of severe pain associated with an oral or maxillofacial condition;
3. Initial treatment for acute infection;
4. Immediate and palliative procedures for acute craniomandibular problems and for traumatic injuries to teeth, bone, or soft tissue;
5. Preoperative procedures; and
6. Anesthesia appropriate for optimal patient management.

B. Covered denture services include medically necessary dental services and procedures associated with, and including, the provision of dentures.

R9-30-211. Transportation Services

A. Emergency ambulance services.
1. Emergency ambulance transportation shall be a covered service for a member. Payment shall be limited to the cost of transporting the member in a ground or air ambulance:
   a. To the nearest appropriate provider or medical facility capable of meeting the member's medical needs; and
   b. When no other means of transportation is both appropriate and available.
2. A ground or air ambulance transport that originates in response to a 911 call or other emergency response system shall be reimbursed according to the terms and conditions that the ~~PSA~~ Administration specified in the contractor's contract, if the medical condition at the time of transport justified a medically necessary or emergency ambulance transport. No prior authorization is required for reimbursement of these transports.
3. Determination of whether transport is medically necessary shall be based upon the medical condition of the member at the time of transport.
4. A ground or air ambulance provider furnishing transportation in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure to notify the contractor may constitute cause for denial of claims.

B. Medically necessary nonemergency transportation. A member is responsible for the full cost of any nonemergency transportation under Laws 2001, Ch. 385, § 13.

R9-30-212. Medical Supplies, Durable Equipment, and Orthotic and Prosthetic Devices

A. Medical supplies, durable equipment, and orthotic and prosthetic devices shall be covered services if:
1. Prescribed for a member by the member's primary care provider, unless referral is waived by the contractor; or
2. Provided in compliance with requirements of this Chapter; and
3. Provided in compliance with the contractor's requirements.

B. Medical supplies include consumable items covered under Medicare that are provided to a member and that are not reusable.

C. Medical equipment includes any durable item, appliance, or piece of equipment that is designed for a medical purpose, is generally reusable by others, and is purchased or rented for a member.

D. Prosthetic and orthotic devices include only those items that are essential for the habilitation or rehabilitation of a member.

E. Prescriptive lenses are covered if they are the sole prosthetic device after a cataract extraction.

F. The following limitations apply:
1. If medical equipment cannot be reasonably obtained from alternative resources at no cost, the medical equipment shall be furnished on a rental or purchase basis, whichever is less expensive. The total expense of renting the equipment shall not exceed the cost of the equipment if purchased.
2. Reasonable repair or adjustment of purchased medical equipment shall be covered if necessary to make the equipment serviceable and if the cost of repair is less than the cost of renting or purchasing another unit.
3. Changes in, or additions to, an original order for medical equipment shall be approved by the member's primary care provider or authorized prescriber and shall be indicated clearly and initialed by the vendor. No change or addition to the original order for medical equipment may be made after a claim for services has been submitted to the member's contractor, without prior written notification of the change or addition.
4. Rental fees shall terminate:
   a. No later than the end of the month in which the primary care provider or authorized prescriber certifies that the member no longer needs the medical equipment;
   b. When the member is no longer eligible for ~~PSDP~~ PSP services; or
   c. When the member is no longer enrolled with a contractor, with the exception of transition of care as specified by the Director.
5. Personal incidentals, including items for personal cleanliness, body hygiene, and grooming, shall not be covered unless needed to treat a medical condition and provided in accordance with a prescription.
6. First aid supplies shall not be covered unless they are provided in accordance with a prescription.
7. Hearing aids and prescriptive lenses shall not be covered for a member who is ~~21~~ 18 years of age and older, unless authorized under subsection (E).

G. Liability and ownership.
1. Purchased durable medical equipment provided by a contractor for a member, but which is no longer needed, may be disposed of in accordance with each contractor's policy.
2. The contractor shall retain title to purchased durable medical equipment supplied to a member who becomes ineligible or no longer requires its use.
3. If customized durable medical equipment is purchased by the contractor for a member, the equipment will remain with the person during times of transition or if the person becomes ineligible.
   a. For purposes of this Section, customized durable medical equipment refers to equipment that has been altered or built to specifications unique to a member's medical needs and which, most likely, cannot be used or reused to meet the needs of another person.
   b. Customized equipment obtained fraudulently by a member shall be returned for disposal to the member's contractor if the customized equipment was purchased for a member.

R9-30-213. ~~Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT)~~ Health Risk Assessment and Screening Services

A. The following ~~EPSDT~~ services shall be covered for a member less than ~~21~~ 18 years of age:
1. Screening services, including:
   a. Comprehensive health and developmental history;
   b. Comprehensive unclothed physical examination;
   c. Appropriate immunizations according to age and health history;
   d. Laboratory tests; and
   e. Health education, including anticipatory guidance;
2. Vision services, including:
   a. Diagnosis and treatment for defects in vision;
   b. Eye examinations for the provision of prescriptive lenses; and
   c. Provision of prescriptive lenses;
3. Hearing services, including:
   a. Diagnosis and treatment for defects in hearing;
   b. Testing to determine hearing impairment; and
   c. Provision of hearing aids;
4. Dental services including:
   a. Emergency dental services as specified in R9-30-207;
   b. Preventive services including screening, diagnosis, and treatment of dental disease; and
   c. Therapeutic dental services including fillings, crowns, dentures, and other prosthetic devices;
5. Orthognathic surgery; and
6. Behavioral health services specified in this Chapter;

B. All providers of ~~EPSDT~~ services shall meet the following standards:
1. Provide services by, or under the direction of, the member's primary care provider or dentist;
2. Perform tests and examinations in accordance with the ~~AHCCCS~~ Administration Periodicity Schedule.

a. Refer members as necessary for dental diagnosis and treatment, and necessary specialty care.
b. Refer members as necessary for behavioral health evaluation and treatment services.

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-30-301. General Requirements

~~**A.** Expenditure limit. Enrollment in the PSP is limited to funding under A.R.S. § 36-2923.01. The PSA will accept members subject to the availability of funds. The PSA shall place all eligible household members on a waiting list when the PSA projects that the program's appropriation will be expended for members. For this subsection, "members" includes persons who have requested a hearing regarding a discontinuance.~~

A. Expenditure limit. Enrollment is limited to funding under A.R.S. § 36-2923.01. The Administration will accept applications subject to the availability of funds. If the Administration determines that enrollment must be suspended due to the limitation of funding, the Administration shall use the waiting list process under subsection (E).

B. Participation. Subject to the expenditure limitation specified in subsection (A) and the cap and waiting list requirements in subsections (D) and (E), a person who meets all eligibility requirements shall be approved and shall pay:
1. A copayment every time a service is received, and
2. A monthly income-based premium paid in full and within the member's payment responsibility under R9-30-701. Failure of the member to make payments under this subsection is cause for termination of PSP coverage.

C. Health history questionnaire. Each eligible household member shall complete and return a health history questionnaire with the ~~first premium payment.~~ initial payment of two monthly premiums.

D. Chronically ill cap.
~~1. The total number of chronically ill members in the PSP shall not exceed 200 persons under A.R.S. § 36-2923.01. When the PSP has reached the cap of 200 persons, and subject to the expenditure limit as specified in subsection (A), a household with an eligible chronically ill person shall be placed on a waiting list.~~
~~2. The chronically ill cap applies to each chronically ill applicant whose gross income is less than or equal to 400 percent FPL.~~
1. The chronically ill cap applies to each chronically ill applicant whose gross income is less than or equal to 400 percent FPL.
2. The total number of chronically ill members in the PSP shall not exceed 200 persons under A.R.S. § 36-2923.01 and is subject to the expenditure limit under subsection (A).
3. If the Administration determines that enrollment must be suspended due to the limitation of funding, the Administration shall use a waiting list as described in subsection (E).

E. Waiting list requirements.
1. General requirements.
   a. The ~~PSA~~ Administration shall maintain separate lists for households with an eligible chronically ill person and households with no eligible chronically ill persons.
   b. Until the 200 person cap in subsection (D) has been reached, a household with an eligible chronically ill person takes priority over a household with no eligible chronically ill persons.
   ~~c. Subject to subsections (E)(2), and (3) the PSA shall place all eligible household members on a waiting list in order of the household's eligibility determination date. The eligibility determination date shall be the date that PSA determines that all conditions of eligibility have been met. The PSA shall process mail received at PSA in the order it is received, by calendar date.~~
   c. Subject to subsections (E)(2), and (3) the Administration shall place an applicant on a waiting list in the order the application is received, by the calendar date as evidenced by the Administration's date stamp on the application with the following exception. The Administration shall give first priority on the wait list to a parent who:
      i. Was enrolled in PSP immediately prior to eligibility under A.R.S. § 36-2981.01; and
      ii. Would retain eligibility under A.R.S. § 36-2981.01 except for the child's loss of eligibility, unless the reason for ineligibility is non-payment of the child's or parent's monthly premium.
   d. The ~~PSA~~ Administration shall enroll an eligible person in a household when sufficient spaces are available to enroll all eligible household members.
   ~~e. No later than the 45th day following the date of notice from PSA that space is available, the household shall submit two months' of premiums and a complete health history questionnaire under subsection (C). The PSA shall enroll all eligible household members under R9-30-304.~~
   e. When space and funding is available, the Administration shall notify applicants, in writing, of the availability of spaces.
   f. The Administration shall request that the applicant submit updated information or a new application as appropriate.
   g. The Administration shall notify each applicant regarding the outcome of the eligibility determination. If the applicant is determined eligible, the Administration shall mail a written notice that instructs the eligible person to submit an initial premium payment, in full, for the first two months of coverage prior to the initial enrollment.

h. If the Administration receives the full premium payment on or before the 15th day of the month following the date of the notice, enrollment will begin on the first day of the next month. If the Administration receives the full premium payment after the 15th day of the month following the date of the notice, coverage begins on the first day of the second month. No retroactive coverage is available.

2. Waiting list for a household with an eligible chronically ill person. If a member of an enrolled household with no eligible chronically ill persons is determined chronically ill, the member shall:
   a. Take priority over a new application ~~applicant~~ for a household with an eligible chronically ill person, ~~and~~ or
   b. Remain in the general population until a chronically ill space is available.
3. Waiting list for households with no eligible chronically ill persons. If a chronically ill member of a household with income equal to or below ~~250~~ 200 percent FPL is determined no longer chronically ill, that person takes priority over a new application for a household with no eligible chronically ill persons.
4. Termination from a waiting list. ~~An eligible person in a household on the waiting list shall be terminated from the waiting list for any of the following reasons:~~ The Administration shall terminate an applicant from the wait list for any of the following reasons:
   a. The person ~~no longer meets~~ does not meet the eligibility requirements of this Article;
   b. Verification of the death of a person;
   c. Voluntary withdrawal of the application for the PSP;
   d. The person cannot be located and mail sent to the person is returned as undeliverable;
   e. The household fails to pay the first two months' of premiums and complete the health history questionnaire; or
   f. Verification of other insurance coverage.

R9-30-302. Time-frames for Determining Eligibility

A. ~~The~~ ~~PSA~~ The Administration shall review the application in date order and contact the applicant if additional information and verification is needed to complete the eligibility determination.

B. Provisions of verification:
1. An applicant shall provide the ~~PSA~~ Administration with information and corresponding verification requested in subsection (A) within 15 days following the date the information and verification was first requested by the ~~PSA~~ Administration.
2. The ~~PSA~~ Administration shall extend the time period by 10 days if before the expiration of the time period allotted in subsection (B)(1) the head-of-household requests additional time.

C. Unless the Administration has suspended applications under Section R9-30-301(A), ~~The~~ ~~PSA~~ the Administration shall determine eligibility in the order that all information necessary to determine eligibility is received by ~~PSA~~ the Administration, by the calendar date that the Administration receives and date stamps the application. ~~and within 30 days of receipt of that information.~~

R9-30-303. Conditions of Eligibility

A. General eligibility requirements.
1. Citizenship/alien status. An applicant shall meet one of the following requirements:
   a. Be a United States citizen as specified in A.R.S. § 36-2903.01 and A.R.S. § 36-2923.01; or
   b. Be a qualified alien as specified in A.R.S. § 36-2903.01.
2. Residency. An applicant shall be a resident of Arizona under A.R.S. § 36-2923.01.
3. Income.
   a. The ~~PSA~~ Administration shall determine the annualized gross household income from documentation submitted by the applicant that identifies income received by all household members during the full calendar month immediately prior to the month of application.
   b. The ~~PSA~~ Administration shall count the annualized gross income from employment, self-employment, rental, public assistance benefits, and other earned and unearned income.
   c. The ~~PSA~~ Administration shall deduct the following amounts from the gross household income:
      i. Payments paid to cover the costs of doing business,
      ii. Payments paid to cover the costs of producing income from rental property as specified in the PSP policy manual, and
      iii. Repayment of advances or overpayments by the same payer when those repayments are deducted directly from the income being considered.
   d. The ~~PSA~~ Administration shall disregard the following income:
      i. Food stamps,
      ii. Earned income tax credits, and
      iii. Any portion of lump-sum income intended to cover a period of time prior to the one-month income period in R9-30-303.
   e. ~~PSA~~ The Administration shall average income if income is received irregularly or regularly but from sources or in amounts ~~which~~ that vary as follows:

i. Add together income from a representative number of weeks or months, and
ii. Divide the resulting sum by the same number of weeks or months to determine the average monthly amount.

f. ~~PSA~~ The Administration shall prorate income if income received is intended to cover a fixed period of time. The income received shall be averaged over the period of time the income is intended to cover to determine a monthly prorated amount.

g. ~~PSA~~ The Administration shall evaluate income under a fixed-term employment contract as follows:
i. If contract income is received on a monthly or more frequent basis throughout all months of the contract, count the income in the month received;
ii. If contract income is received before or during the time the work is performed, but not as specified in subsection (A)(3)(g)(i), prorate the income over the number of months in the contract; or
iii. If payment is received only upon completion of the work, the ~~PSA~~ Administration shall divide the amount of the contract-payment by the number of months in the contract.

h. ~~PSA~~ The Administration shall use the actual amount of income received in a month if the applicant:
i. Receives or expects to receive less than a full month's income from a new source,
ii. Loses a source of income, or
iii. Is paid daily.

4. Income limits. The annualized gross household income, less deductions shall not exceed ~~250~~ 200 percent of the FPL for a nonchronically ill member and 400 percent FPL for a chronically ill person under ~~A.R.S. § 36-2923.01(L).~~ A.R.S. § 36-2923.01.

5. Income verification.
a. The applicant shall provide verification for all sources of income received by all household members during the full calendar month immediately prior to the month of application.
b. If the applicant fails to provide verification of income, the ~~PSA~~ Administration shall deny the application.

6. Household composition. The ~~PSA~~ Administration determines eligibility by household unit. All members of the household shall be included on the application. In computing the household size and income limit, a pregnant woman is counted as a minimum of two persons. The following persons, when living together, are members of the same household:
a. Head-of-household;
b. A spouse as defined in A.A.C. R9-22-101. This includes a spouse who is temporarily away from home for employment or to seek employment;
c. Other parent. The other parent or guardian of a common dependent child when that person is not the spouse of the head-of-household; and
d. A dependent child means a child who is unmarried, has not reached age 19, and
i. Is a biological child, adopted child, a step-child of the head-of-household or spouse or both, or
ii. The biological child of another dependent child who is a household member, or
iii. A child for whom the head-of-household or spouse is a legal guardian unless that child's adult parent is sharing the residence.

7. Cooperation. An applicant shall cooperate in providing the necessary information to verify eligibility.

8. Fraud. An applicant who has been convicted of fraud or abuse under A.R.S. § 36-2923.01 is not eligible to participate in the Premium Sharing Program.

9. Other health care coverage.
a. An applicant who has health care coverage or who voluntarily terminated health care coverage in the 30 days prior to application for the PSP, including but not limited to any of the following applicants, is not eligible for coverage under the PSP under A.R.S. § 36-2923.01:
i. An applicant who voluntarily terminated federal or state-funded health care coverage, except voluntary PSP terminations, which must wait 12 months under R9-30-305;
ii. An applicant who had COBRA and who terminated COBRA before exhausting COBRA coverage;
iii. An applicant who had COBRA and who terminated COBRA due to nonpayment of a premium;
iv. An applicant who voluntarily terminated employment or was terminated due to gross misconduct or for cause;
v. An applicant who failed to cooperate with the requirements of federal or state-funded health care coverage; and
vi. An applicant who terminated health care coverage for non-payment of premiums or copayments.
b. Exclusions from the 30 days bare requirement. An applicant who involuntarily terminated health care coverage in the 30 days prior to application for the PSP, including but not limited to any of the following applicants, is excluded from the 30 days bare requirement in subsection (A)(9)(a):
i. An applicant whose employer terminated the applicant's employment other than for cause or gross misconduct;
ii. An applicant whose employer altered the applicant's employment status, such as changing the applicant's

hours from full-time to part-time;
iii. An applicant who involuntarily terminated health care coverage due to divorce from an insured spouse;
iv. An applicant who involuntarily terminated health care coverage due to death of an insured spouse;
v. An applicant who became ineligible for coverage under the applicant's parent's insurance due to age or student status;
vi. An applicant who involuntarily terminated health care coverage due to a loss of a job and who did not have the option to participate in COBRA;
vii. An applicant who involuntarily terminated health care coverage due to a loss of a job and who had the option to participate in COBRA but who chose not to participate or pay the initial payment;
viii. An applicant who involuntarily terminated health care coverage due to a loss of a job and who chose to participate in COBRA and exhausted COBRA coverage; and
ix. An applicant who became ineligible for health care coverage by reaching a lifetime cap on expenditures imposed by the applicant's insurer.

10. Other limitations.
~~a. Veterans Administration (VA) coverage. An applicant who has VA coverage for a medical condition is not eligible for coverage of only that medical condition or medical conditions under the PSP. A person who has full VA coverage shall not be eligible for PSP.~~
a. Veterans Administration (VA) coverage. An applicant who has coverage limited to the applicant's service related injuries under the VA is eligible for PSP limited to those medical conditions not covered under the VA.
b. Medicare benefits. An applicant who ~~has~~ is eligible for Medicare Part A, Medicare Part B, or both, is not eligible for coverage under the PSP.
c. AHCCCS benefits. An applicant who is eligible for AHCCCS medical benefits or KidsCare under ~~A.R.S. Title 11, Chapter 2, or~~ A.R.S. Title 36, Chapter 29, Article 2 or 4, is not eligible for the PSP. The ~~PSA~~ Administration may screen an application to determine if an applicant is eligible for any of these programs. An applicant shall declare whether the applicant has been determined ineligible for these programs. An applicant is encouraged to apply for AHCCCS benefits or KidsCare prior to approval for the PSP.
d. Exceptions to AHCCCS benefits. Women who are eligible for family planning assistance under the Sixth Omnibus Budget Reconciliation Act (SOBRA) may apply for the PSP under A.R.S. § 36-2923.01.
e. Payor of last resort. The ~~AHCCCS~~ Administration is the payor of last resort under A.R.S. § 36-2923.01. The ~~PSA~~ contractor shall not be the primary payor for any claim involving worker's compensation, automobile insurance, or homeowner's insurance.

B. Additional requirements for a chronically ill member or applicant.
1. Limited enrollment. There is a 200-space limit for the chronically ill. The ~~PSA~~ Administration shall place an applicant or member on a waiting list once the spaces are filled or expenditure limits are reached under A.R.S. § 36-2923.01.
2. Other health care coverage. The requirements in subsection (A)(9) do not apply to a chronically ill member or applicant who has an annual gross household income greater than ~~250~~ 200 percent but equal to or less than 400 percent of FPL.
3. Chronic illness coverage. The following limitations shall apply for any applicant who meets the requirements for coverage as a chronically ill member as specified in R9-30-102.
a. Medical verification. A member or applicant who is chronically ill shall submit a written statement from a physician indicating that the illness meets the definition of chronic disease as specified in R9-30-102.
b. Premium. A chronically ill member or applicant and each household member whose gross household income is equal to or less than 400 percent FPL but greater than ~~250~~ 200 percent FPL shall pay the full premium under A.R.S. § 36-2923.01.
c. Failure to claim chronic disease. A chronically ill member who fails to state that the member has one of the chronic diseases under Laws 2001, Ch. 385, § 14 and R9-30-102 at the time of application may be denied, referred to the ~~PSA~~ Administration for potential fraud, or both.

R9-30-304. Enrollment
A household shall pay the premiums for eligible household members under A.R.S. § 36-2923.01 for continued enrollment in the PSP.
1. Contractor choice.
a. Each eligible household shall select a contractor at the time of application.
b. ~~PSA~~ The Administration shall enroll all eligible household members with the same contractor.
c. Each eligible household shall have freedom of choice of a PSP contractor when there are one or more contractors in the service area.
2. Open enrollment. The eligible household may change contractors during the annual enrollment choice period.
3. Effective date of enrollment. The ~~PSA~~ Administration shall enroll all eligible household members with the contractor under R9-30-701. Members shall be ineligible for retroactive coverage.

R9-30-305. Disenrollment

A. A member shall be disenrolled from the PSP under A.R.S. § 36-2923.01 for the following reasons:
1. Nonpayment of premiums for the household;
2. Untimely payments;
3. Providing false or fraudulent information on the Premium Sharing application;
4. Violence, or threatening or other substantially abusive behavior toward the ~~PSA~~ Administration or the PSP employees or agents, or contracting or noncontracting providers or their employees or agents;
5. The person no longer meets the eligibility requirements identified in R9-30-303 and A.R.S. § 36-2923.01; or
6. Failure or refusal to cooperate in the eligibility process or provide requested information.

B. A member who is confined to a hospital on the effective date of disenrollment shall continue to receive coverage until the contractor's Medical Director or designee determines that care in the hospital is no longer medically necessary for the condition for which the member was admitted or the member is discharged from the hospital.

C. Grievance and request for hearing process. A member has a right to file a grievance or request for hearing as specified in Article 6.

D. PSP participation. A member who voluntarily terminates PSP eligibility shall not re-enroll for a period of 12 consecutive months under A.R.S. § 36-2923.01. The 12-month period begins with the date of disenrollment and continues for 12 full calendar months.
1. Disenrollment from the PSP or nonpayment of a premium is a voluntary termination and subject to the 12-month period.
2. Voluntary termination from PSP does not include a disenrollment from the PSP because of a change in employment status ~~which~~ that causes the member's gross household income to exceed the income limit.

E. Health Insurance Portability and Accountability Act of 1996. A member who has been disenrolled shall be allowed to use enrollment in the PSP as creditable coverage as defined in P.L. 104-191 under ~~A.R.S. § 36-2923.01(P).~~ A.R.S. § 36-2923.01.

R9-30-306. Redetermination

A. Except as provided in subsection (C), the ~~PSA~~ Administration shall conduct a redetermination of eligibility on each Premium Sharing household unit no less often than every 12 months under A.R.S. 36-2923.01 unless the household unit becomes ineligible prior to this time.

B. The 12-month period shall begin with the first day of the month following the eligibility determination date as determined under R9-30-301 or the most recent redetermination date.

C. The ~~PSA~~ Administration shall conduct a redetermination on a household unit when the ~~PSA~~ Administration has reason to believe that a member's situation has changed and the change may affect eligibility or the premium amount paid by the member or household.

ARTICLE 4. ~~CONTRACTS~~ REPEALED

R9-30-401. ~~General Provisions~~ Repealed

~~**A.** Requirements. The PSA and qualified providers of health care who have contracts to provide services under AHCCCS shall conform to the requirements in this Article and A.R.S. § 36-2923.01. A contractor that has contracts and subcontracts entered into under this Article shall have records on file.~~

~~**B.** Contract. A contract may be cancelled or rejected in whole or in part, as specified in contract if it is deemed by the Director to be in the best interest of the state. The reasons for cancellation or rejection shall be made part of the contract file.~~

~~**C.** Damages or claims. Offerors as defined in R9-22-106 shall have no right to damages or basis for any claims against the state, its employees, or agents, arising out of any action by the PSA Administration under the provisions of subsection (B).~~

R9-30-403. ~~PSA's Contracts with Contractors~~ Repealed

~~**A.** The Administration is authorized to contract with contractors under A.R.S. § 36-2923.01.~~

~~**B.** If the Director determines there is insufficient coverage in a county, the Director shall attempt to contract with a prepaid capitated provider as defined in A.R.S. § 36-2901, to provide services under the PSP under A.R.S. § 36-2923.01(A).~~

~~**C.** Each contract between the PSA and a contractor shall be in writing and contain at least the following information:~~
~~1. The method and amount of compensation or other consideration to be received by the contractor;~~
~~2. The name and address of the contractor;~~
~~3. The population to be covered by the contract;~~
~~4. The amount, duration, and scope of medical services to be provided, or for which compensation will be paid;~~
~~5. The term of the contract, including the beginning and ending dates, as well as methods of extension, renegotiation, and termination;~~
~~6. A provision that the Director may evaluate, through inspection or other means, the quality, appropriateness, or timeliness of services performed under the contract;~~

7. ~~A description of member, medical and cost recordkeeping systems, and a provision that the Director may audit and inspect any of the contractor's records that pertain to services performed and determinations of amounts payable under the contract;~~
8. ~~Records shall be maintained by the contractor for five years from the date of final payment or, for records relating to costs and expenses to which the PSA has taken exception, five years after the date of final disposition or resolution of the exception;~~
9. ~~A provision that contractors maintain all forms, records, and statistical information required by the Director for purposes of audit and program management. This material, including files, correspondence, and related information pertaining to services rendered or claims for payments shall be subject to inspection and copying by the PSA during normal business hours at the place of business of the person or organization maintaining the records;~~
10. ~~A provision that the contractor safeguard information;~~
11. ~~A provision that the contractor arrange for the collection of any required copayment by the provider;~~
12. ~~A provision that the contractor will not bill or attempt to collect from a member for any covered service except as may be authorized by statute or rules in this Chapter;~~
13. ~~A provision that the contract will not be assigned or transferred without the prior approval of the Director;~~
14. ~~Procedures and criteria for terminating the contract;~~
15. ~~Procedures for terminating enrollment;~~
16. ~~Procedures for choice of health professionals;~~
17. ~~A provision that a contractor provide for an internal grievance procedure that:~~
    a. ~~Is approved in writing by the PSA;~~
    b. ~~Provides for prompt resolution; and~~
    c. ~~Ensures the participation of persons with authority to require corrective action;~~
18. ~~A provision that the contractor maintain an internal quality management system;~~
19. ~~A provision that the contractor submit marketing plans, procedures, and materials to the PSA for approval before implementation;~~
20. ~~A statement that all representations made by contractors or authorized representatives are truthful and complete to the best of their knowledge;~~
21. ~~A provision that the contractor is responsible for all:~~
    a. ~~Tax obligations;~~
    b. ~~Workers' Compensation Insurance; and~~
    c. ~~All other applicable insurance coverage, for itself and its employees, and that the PSA has no responsibility or liability for any of the taxes or insurance coverage; and~~
22. ~~A provision that the contractor agrees to comply with all applicable statutes, rules, and policies.~~

R9-30-404. ~~Subcontracts~~ Repealed

~~A.~~ ~~Approval. A contractor entering into a subcontract to provide services to a member must meet the requirements specified in the contract. A subcontract and any amendment to a subcontract shall be subject to review and approval by the Director.~~

~~B.~~ ~~Subcontracts. Each subcontract shall be in writing and include:~~

1. ~~The subcontract that is to be governed by, and construed in accordance with all laws, rules, policies, and contractual obligations of the contractor;~~
2. ~~Provision to notify the PSA in the event the subcontract is amended or terminated;~~
3. ~~Provision that assignment or delegation of the subcontract is voidable, unless prior written approval is obtained from the PSA;~~
4. ~~Provision to hold harmless the state, the Director, the PSA and a member in the event the contractor cannot or will not pay for covered services performed by the subcontractor;~~
5. ~~Provision that the subcontract and subcontract amendments are subject to review and approval by the Director as established in these rules and that a subcontract or subcontract amendment may be terminated, rescinded, or cancelled by the Director for a violation of these rules;~~
6. ~~Provision to hold harmless and indemnify the state, the Director, the PSA or a member, through the negligence of the subcontractor;~~
7. ~~Provision that a member is not to be held liable for payment to a subcontractor in the event of contractor's bankruptcy;~~
8. ~~The method and amount of compensation or other consideration to be received by the subcontractor;~~
9. ~~The amount, duration, and scope of medical services to be provided by the subcontractor, for which compensation will be paid; and~~
10. ~~The requirements contained in R9-30-403(C)(1) through (14) and (C)(20) through (22) but substituting the term "subcontractor" wherever the term "contractor" is used.~~

R9-30-405. ~~Contract Records~~ Repealed

~~All contract records shall be retained for a period of 5 years and disposed of as specified in A.R.S. § 41-2550.~~

R9-30-406. ~~Merger; Reorganizations; Change in Ownership; and Contract Amendments~~ Repealed

~~**A.** Merger, reorganization, or change in ownership. The Director shall prior approve any proposed merger, reorganization, or change in ownership of a contractor.~~

~~**B.** Amendment. The Director shall prior approve any proposed merger, reorganization, or change in ownership of a subcontractor that is related to or affiliated with the contractor and shall require a contract amendment. To be effective, contract amendments shall be in writing and executed by the Director.~~

R9-30-407. ~~Suspension, Modification, or Termination of Contract~~ Repealed

~~**A.** General. The Director may suspend, deny, refuse or fail to renew, or terminate a contract or subcontract for good cause.~~

~~**B.** Modification and termination of the contract without cause. The AHCCCS Administration and contractor, by mutual consent, may modify or terminate the contract at any time without cause. Additionally, the AHCCCS Administration may terminate or suspend the contract in whole or in part without cause effective 30 days after mailing written notice of termination or suspension by certified mail, return receipt requested, to the contractor.~~

~~**C.** Notification.~~

~~1. The Director shall provide the contractor written notice of intent to:~~
~~a. Suspend;~~
~~b. Fail to renew; or~~
~~c. Terminate a contract or related subcontract.~~

~~2. The PSA shall provide a notice to a contractor, a member, and other interested parties, and shall include:~~
~~a. The effective date; and~~
~~b. Reason for the action.~~

~~**D.** Records. All medical, financial, and other records shall be retained by a terminated contractor in accordance with state laws and rules. Medical records or copies of medical records may be required to be submitted to the Director, or designee, within 10 working days of the effective date of contract termination~~.

R9-30-408. ~~Contract Compliance Sanction Alternative~~ Repealed

~~The Director may impose a sanction upon a contractor that violates any provision of the rules as specified in contract.~~

R9-30-409. ~~Contract or Protest; Request for Hearing~~ Repealed

~~The contractor shall file a grievance as specified in A.A.C. R9-22-804.~~

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-30-501. General Authority

The Director shall administer ~~and implement~~ the PSP and has full operational authority to carry out administrative functions under A.R.S. § 36-2923.01.

R9-30-507. Member Record

A contractor shall maintain a member service record that contains at least the following for each member:

1. Encounter data, if required by ~~PSA;~~ the Administration;
2. Grievances and request for hearings;
3. Any informal complaints; and
4. Service information.

R9-30-509. Transition and Coordination of Member Care

The ~~PSA~~ Administration shall coordinate and implement disenrollment and re-enrollment procedures when a member's change of residence requires a change in contractor as specified in contract.

R9-30-511. Fraud and Abuse

A contractor, provider, or noncontracting provider shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse ~~as specified in R9-30-303.~~ under this Chapter.

R9-30-512. Release of Safeguarded Information by the PSA and a Contractor

A. The ~~PSA~~ Administration, a contractor, a provider, and a noncontracting provider shall safeguard information concerning an applicant, or a member, which includes the following:
1. Name and address;
2. Social Security number;
3. Social and economic conditions or circumstances;
4. Agency evaluation of personal information;
5. Medical data and services, including diagnosis and history of disease or disability;
6. Information from the Arizona Department of Economic Security or ~~AHCCCSA~~ the Administration, if required;

B. The restriction upon disclosure of information does not apply to:
1. Summary data,
2. Statistics,

3. Utilization data, and
4. Other information that does not identify a member.

C. The ~~PSA~~ Administration, a contractor, a provider, and a noncontracting provider shall use or disclose information concerning a member only under the conditions specified in subsection (D), (E), and (F) and only to:
1. The person concerned,
2. A person authorized by the person concerned, and
3. A person or agency for official purposes.

D. Safeguarded information shall be viewed by or released to only:
1. An applicant;
2. A member; or
3. A dependent child, with written permission of a parent, custodial relative, or designated representative, if:
   a. ~~A PSA~~ An Administration employee or authorized representative, or responsible caseworker is present during the examination of the eligibility record; or
   b. As outlined in subsection (E) after written notification to the provider, and at a reasonable time and place.

E. An eligibility case record, medical record, and any other ~~PSP-~~related confidential and safeguarded information regarding a member or applicant, shall be released to a person authorized by the member or applicant, only under the following conditions:
1. Authorization for release of information is obtained from the member, applicant, or designated representative;
2. Authorization used for release is a written document, separate from any other document~~,~~ that specifies the following information:
   a. Information or records, in whole or in part, which are authorized for release;
   b. To whom release is authorized;
   c. The period of time for which the authorization is valid, if limited; and
   d. A dated signature of the adult and mentally competent member, applicant, or designated representative. If a member, or applicant is a minor, the signature of a parent, custodial relative, or designated representative shall be required unless the minor is sufficiently mature to understand the consequences of granting or denying authorization. If a member or applicant is mentally incompetent, authorization shall be under A.R.S. § 36-509; or
3. If a request for hearing or grievance is filed, the member, applicant, or designated representative shall be permitted to review and obtain or copy any nonprivileged record necessary for the proper presentation of the case.

F. Release of safeguarded information to individuals or agencies for official purposes:
1. Official purposes directly related to the administration of the PSP are:
   a. Establishing eligibility and post-eligibility treatment of income, as applicable;
   b. Providing services for a member;
   c. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding ~~related to the PSP~~; and
   d. Performing evaluations and analyses of PSP operations;
2. For official purposes related to the administration of the PSP and only to the extent required in performance of duties, safeguarded information, including case records and medical records, may be disclosed to the following persons without the consent of the applicant, or member:
   ~~a. Employees of the PSA;~~
   ~~b.~~a. Employees of the ~~AHCCCS~~ Administration;
   ~~c.~~b. Employees of the U.S. Social Security Administration;
   ~~d.~~c. Employees of the Arizona Department of Economic Security;
   ~~e.~~d. Employees of the Arizona Department of Health Services;
   ~~f.~~e. Employees of the U.S. Department of Health and Human Services;
   ~~g.~~f. Employees of contractors, program contractors, providers, and subcontractors; and
   ~~h.~~g. Employees of the Arizona Attorney General's Office, and the County Attorney, if applicable.
3. Law enforcement officials:
   a. Information may be released to law enforcement officials without the applicant's or member's written or verbal consent, for the purpose of an investigation, prosecution, or criminal or civil proceeding relating to the administration of the PSP.
   b. The ~~PSA~~ Administration and contractors shall release safeguarded information contained in an applicant's or member's medical record to law enforcement officials without the member's consent only if the applicant or member is suspected of fraud or abuse against the PSP.
4. The ~~PSA~~ Administration may release safeguarded information including case records and medical records to a review committee in accordance with the provisions of A.R.S. § 36-2917, without the consent of the applicant or member.
5. Providers shall furnish requested records to the ~~PSA~~ Administration and its contractors at no charge.

G. The holder of a medical record of a former applicant or member shall obtain written consent from the former applicant, or member before transmitting the medical record to a primary care provider.

H. Subcontractors are not required to obtain written consent from a member before transmitting the member's medical records to a physician who:
1. Provides a service to the member under subcontract with the contractor;
2. Is retained by the subcontractor to provide services that are infrequently used or are of an unusual nature; and
3. Provides a service under the contract.

R9-30-513. Discrimination Prohibition
A contractor, provider, and ~~nonprovider~~ noncontracting provider shall not discriminate against a member as specified in federal and state law.

R9-30-514. Equal Opportunity
~~A contractor shall meet the requirements in Title VII of the U.S. Civil Rights Act of 1964, 42 U.S.C. 2000(e). A contractor shall, in all solicitations or advertisements for employees placed by, or, on behalf of the contractor:~~
~~1. Specify that it is an equal opportunity employer;~~
~~2. Send a notice to each labor union representative or worker with a collective bargaining agreement, or other contract or understanding, stating that the contractor is an equal opportunity employer; and~~
~~3. Post copies of the notice in conspicuous places available to employees and applicants for employment.~~
The contractor shall comply with equal opportunity requirements under A.A.C. R9-22-514.

R9-30-520. Financial Statements, Periodic Reports, and Information
Upon request by the ~~PSA~~ Administration, a contractor shall furnish to the ~~PSA~~ Administration financial statements, periodic reports, and information from its records relating to contract performance as specified in contract.

R9-30-521. Program Compliance Audits
The ~~PSA~~ Administration may conduct a program compliance audit of each contractor on a periodic basis as specified in contract.

R9-30-522. Quality Management/Utilization Management (QM/UM) Requirements
A ~~PSA~~ contractor shall comply with the quality management and utilization review requirements as specified in contract.

R9-30-523. Financial Resources
A. A contractor or offeror shall demonstrate upon request by the ~~PSA~~ Administration that it has:
1. Adequate financial reserves;
2. Administrative abilities; and
3. Soundness of program design to carry out its contractual obligations.

B. As specified in A.R.S. § 36-2912, the Director requires that contract provisions include, but not be limited to:
1. Maintenance of deposits;
2. Performance bonds unless waived as specified in A.R.S. § 36-2912;
3. Financial reserves; or
4. Other financial security, unless waived as specified in A.R.S § 36-2912.

ARTICLE 6. GRIEVANCE AND REQUEST FOR HEARING

R9-30-601. General Provisions for a Grievance and a Request for Hearing
~~**A.**~~ A grievance and a request for hearing under this Chapter shall comply with R9-22-801. ~~All references in that rule to AHCCCS shall apply to PSA, and all references to contractors and system providers shall apply to Premium Sharing Plans.~~ The grievance and request for hearing process is illustrated in Exhibit A.
~~**B.** When requesting a hearing regarding an adverse action under this Chapter, PSA is the respondent.~~

R9-30-602. Grievance
General requirements. A grievance under this Chapter shall be filed and processed under R9-22-802. ~~All references in that rule to AHCCCS shall apply to the PSA and all references to contractors shall apply to Premium Sharing Plans. The grievance process is illustrated in Exhibit A.~~

R9-30-603. Eligibility Hearing for an Applicant and a Member
A. Except as provided in this Section, an eligibility hearing for an applicant or a member shall comply with R9-22-803.
B. Adverse eligibility action. An applicant and a member may request a hearing concerning any of the following adverse eligibility actions:
1. Denial of eligibility. A denial of eligibility is an adverse decision that determines an applicant ineligible for PSP;
2. Discontinuance of eligibility. A discontinuance of eligibility is a termination of a member's eligibility for PSP;
3. Determination of premium amount; or
4. Determination of chronic illness.

C. ~~PSP coverage~~ Coverage during the hearing process. A member who requests a hearing regarding a discontinuance shall receive continued Premium Sharing coverage until a final administrative decision is rendered only if the member pays for

a minimum of three full months ~~worth~~ of premiums under R9-30-701, which shall be received no later than 15 days after the date of notice. In the event the final administrative decision is not rendered within three months, the member shall continue to pay monthly premiums. Failure to timely pay monthly premiums in full shall result in the termination of coverage.

D. Non-refundable premium. The Administration shall not refund any portion of the ~~advance premiums paid.~~ advance three month premium.
1. If a member's discontinuance is upheld, any remaining advance premium paid shall be applied toward the cost to the system.
2. If a member's discontinuance is overturned, any remaining advance premium paid shall be applied to the next month's premium charge.

E. Refundable premium. The Administration may refund a monthly premium if:
1. The member pays premiums beyond the non-refundable three month advance premium, and
2. Prior to the month of coverage of the services, the member's discontinuance is upheld. Once a premium is refunded the PSP coverage will terminate at the end of the previous month.

ARTICLE 7. PAYMENT RESPONSIBILITIES

R9-30-701. A Member's Payment Responsibilities

A. Premium payment requirement. A member shall pay in full the required premium payment established by the ~~PSA~~ Administration under A.R.S. § 36-2923.01.

B. Monthly premium payment. The monthly premium payment is based on annual household income equal to or less than ~~250~~ 200 percent FPL, determined by the one-month income period. A member whose gross household income is equal to or less than ~~250~~ 200 percent FPL shall pay ~~a share of the premium.~~ the full monthly premium amount to the Administration under subsection (E). The member shall pay the share of the premium depending on the number of eligible household members and the gross household income.
1. For one eligible household member, the premium share will be equal to three percent of the gross household income;
2. For two eligible household members, the premium share will be equal to four percent of the gross household income;
3. For three eligible household members, the premium share will be equal to five percent of the gross household income;
4. For four or more household members, the premium share will be equal to six percent of the gross household income.

C. Premium payment for chronically ill person with gross household income greater than ~~250~~ 200 percent and equal to or less than 400 percent of FPL. The ~~PSA~~ Administration will require the chronically ill members and their eligible household members whose gross household income is greater than ~~250~~ 200 percent and equal to or less than 400 percent of the FPL to pay the full premium as established by the ~~PSA.~~ Administration.

D. Premium payment schedule for initial enrollment. The ~~PSA~~ Administration requires that upon conditional approval of the application, the member shall pay the full premium for the first two months of coverage prior to initial enrollment. If the ~~PSA~~ Administration receives the premium payment on or before the 15th day of the month, enrollment will begin on the first day of the next month. If the ~~PSA~~ Administration receives the premium payment after the 15th day of the month, following the date of the notice, coverage begins on the first day of the second month.

~~**E.** When and how to submit premium. The member shall submit their monthly premium payment to the PSA at least 30 days in advance of the coverage month.~~

E. When and how to submit monthly premium payments. The member shall submit the full monthly premium payment to the Administration by the first day of the month prior to the month of coverage. The monthly premium payment is delinquent if received or postmarked after the 25th day of the month prior to the month of coverage. Monthly premium payments that are untimely shall result in the termination of coverage.
1. All premiums paid in advance by the member are nonrefundable, unless the member is disenrolled at least 15 days prior to the month of coverage. Premiums paid during a grievance under ~~R9-30-602~~ R9-30-603 are nonrefundable.
2. ~~A member's monthly premium shall be paid~~ A member shall pay the full monthly premium with sufficient funds in the form of a:
   a. Cashier's check,
   b. Personal check,
   c. Money order, or
   d. Other means approved by the ~~PSA.~~ Administration.
3. A member whose payment is returned for nonsufficient funds shall pay the full monthly premium in the form of a:
   a. Cashier's check,
   b. Money order, or
   c. Other means approved by the ~~PSA.~~ Administration.

F. Newborns. All newborns shall be enrolled ~~within 31 days~~ 30 days following the ~~of~~ birth to be eligible for coverage. Upon enrollment, the newborn's premium is due to the ~~PSA~~ Administration ~~within 31 days~~ 30 days following the ~~of~~ birth for coverage retroactive to the first day of the month in which the birth occurred.

G. Copayment requirements. A member shall pay the following under ~~A.R.S. § 36-2923.01(B) and (G)~~ A.R.S. § 36-2923.01
1. $10 for each physician visit,
2. $50 for each emergency room visit. This fee shall be waived if the person is admitted to the hospital;
3. $50 for each inpatient stay;
4. Prescriptions:
   a. $5 for generic,
   b. $20 for formulary brand name prescriptions; the generic copayment applies to branded prescription medications for which there is no FDA rated A-B generic equivalent.
5. $8 for each laboratory visit not to exceed $8 per site per day or a maximum copayment of $10 per day for a laboratory visit made on the same day in conjunction with a physician visit;
6. $8 for each x-ray service not to exceed $8 per site, per day or a maximum copayment of $10 per day for a x-ray service made on the same day in conjunction with a physician visit;
7. $50 for each behavioral health admission to an inpatient behavioral facility. Members are eligible for a maximum of 30 days of inpatient behavioral health services annually;
8. $10 for individual outpatient behavioral health services. Members are eligible for a maximum of 30 outpatient behavioral health visits annually;
9. $5 for outpatient behavioral health group services; and
10. The full cost of any nonemergency transportation.

H. A contractor may withhold nonemergency medical services to a member who does not pay copayments in full at the time service is rendered under A.R.S. § 36-2923.01.

R9-30-702. The ~~PSA's~~ Administration's Scope of Liability: The ~~PSA's~~ Administration's Payment Responsibility to Contractors

A. Liability for covered services. The ~~AHCCCS~~ Administration ~~and the PSA~~ shall have no liability for the provision of covered services or for the completion of a plan of treatment to a member beyond the date of disenrollment except when the member is confined to a hospital as specified in R9-30-305. The ~~AHCCCS~~ Administration ~~and the PSA~~ shall be liable until care in the hospital is no longer medically necessary for the condition for which the member was admitted.

B. Subcontracts liability. The ~~AHCCCS~~ Administration ~~and the PSA~~ shall have no liability for subcontracts that a contractor may execute with other parties.

C. Contractor's liability for costs. The contractor shall indemnify and hold the ~~AHCCCS~~ Administration ~~and the~~ ~~PSA~~ harmless from any and all liability arising from the contractor's subcontracts, and shall be responsible for:
1. All costs of defense of any litigation concerning the liability; and
2. Satisfaction in full of any judgment entered against the ~~AHCCCS~~ Administration ~~and the PSA~~ in litigation involving the contractor's subcontracts.

D. Capitation rates. The ~~PSA~~ Administration shall establish actuarially sound capitation rates under ~~A.R.S. § 36-2923.01(L).~~ A.R.S. § 36-2923.01. The ~~PSA~~ Administration may adjust the capitation rates. The oversight committee reviews changes to capitation rates, premiums and copayments under A.R.S. § 36-2923.02.

E. Payments. The ~~PSA~~ Administration shall make all payments to a contractor in accordance with the terms and conditions of the contract executed between the contractor and the ~~PSA~~ Administration and in accordance with these rules.

F. Medical financial risk. The ~~PSA~~ Administration will limit the medical financial risk to contractors associated with the PSP through a risk sharing reconciliation arrangement as specified in contract.

G. Payments made on behalf of a contractor; recovery of indebtedness. The ~~PSA~~ Administration may make payments on behalf of a contractor in order to prevent a suspension or termination of services as specified in A.A.C. R9-22-713.

H. Specialty contracts and payments. The ~~PSA~~ Administration may at any time negotiate or contract for specialty contracts on behalf of providers, and noncontracting providers. The ~~PSA~~ Administration and a contractor shall meet the requirements in A.A.C. R9-22-716.

I. Charges against a member. A contractor, subcontractor, or other provider of services shall not:
1. Charge;
2. Submit a claim; or
3. Demand or otherwise collect payment from a member or person acting on behalf of a member for any covered service except to collect an authorized copayment or payment for a noncovered service. A contractor who makes a claim for a noncovered service shall not charge more than the actual, reasonable cost for providing the service.

J. Collecting payment. Except for copayments under R9-30-701, a provider shall not bill or make any attempt to collect payment, directly or through a collection agency, from a person claiming to be a member without first receiving verification from the ~~PSA~~ Administration that the person was ineligible for PSP on the date of service or that the services provided were not covered by PSP.

K. Member withheld information. The prohibition in subsection (J) shall not apply if the ~~PSA~~ Administration determines that the member willfully withheld information pertaining to the member's enrollment with a contractor. A prepaid capitated contractor shall have the right to recover from a member that portion of payment made by a third-party to the member when the payment duplicates the PSP benefits and the payment has not been assigned to the contractor.

L. First- and third-party collections and coordination of benefits. The ~~PSA~~ Administration shall recover all ~~First-~~ first- and third-party collections and coordinate benefits under 9 A.A.C. 22, Article 10 and A.R.S. § 36-2923.01. The ~~PSA~~ Administration is entitled to all rights for liens and claims under A.R.S. §§ 36-2915 and 36-2916.

R9-30-703. Contractor's and Provider's Claims and Payment Responsibilities

A. General responsibilities. A provider shall submit to a contractor all claims for services rendered to a member enrolled with the contractor. A contractor shall pay for all admissions and covered services provided to a member when the admissions or covered services have been arranged and necessary authorization has been obtained by:
1. A contractor's agent or employee;
2. A subcontracting provider; or
3. Other person acting on the subcontractor's behalf.

B. Claims.
1. Time-frame to pay a claim. A contractor shall reimburse subcontracting and noncontracting providers for the provision of covered services to a member either:
   a. Within the time period specified by contract between a contractor and a subcontracting entity; or
   b. Within 60 days of receipt of a clean claim, if a time period is not specified in contract; or
   c. For a hospital claim, a contractor shall pay a noncontracting provider for inpatient hospital and outpatient hospital services according to the quick pay discount and slow pay penalties as specified in A.R.S. § 36-2903.01.
2. When a contractor is not required to pay a claim. A contractor is not required to pay a claim for covered services that is submitted more than 6 months after the date of the service, or that is submitted as a clean claim more than 12 months after the date of service.
3. Inpatient or outpatient hospital claim. A contractor shall pay the hospitals in accordance with:
   a. How a hospital claim is processed under A.A.C. R9-22-705;
   b. What personal care items are covered under A.A.C. R9-22-717; and
   c. What hospital supplies and equipment are covered under A.A.C. R9-22-717.
4. Review of hospital claims. If a contractor and a hospital do not agree on reimbursement levels, terms and conditions, the requirements specified in A.A.C. R9-22-705 shall apply.
5. Denial and rights of a claimant. A contractor shall provide written notice to a provider whose claim is denied or reduced by the contractor within 60 days of receipt of a claim. This notice shall include a statement describing the provider's right to:
   a. Grieve the contractor's rejection or reduction of the claim; and
   b. Submit a grievance in accordance with A.A.C. R9-22-804.

C. Reimbursement.
1. In-state inpatient hospital reimbursement. A contractor shall reimburse an in-state subcontractor and noncontracting provider for the provision of inpatient hospital services. The contractor may choose among the following reimbursement methodologies depending on the county in which the services are provided.
   a. Maricopa and Pima counties.
      i. A rate specified by subcontract. Subcontract rates, terms and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and A.A.C. R9-22-715; or
      ii. Reimbursement based on the pilot program described in A.A.C. R9-22-718.
   b. For the remaining counties in Arizona.
      i. A rate specified by subcontract. Subcontract rates, terms and conditions are subject to review and approval or disapproval under A.R.S. § 36-2904 and A.A.C. R9-22-715; or
      ii. The prospective tiered-per-diem amount in A.R.S. § 36-2903.01 and A.A.C. R9-22-712.
2. Payment for emergency services and subsequent care. A contractor shall pay for all emergency care services provided to a member by subcontracting and noncontracting providers when a service:
   a. Conforms to the notification requirements in 9 A.A.C. 30, Article 2;
   b. Conforms to the definition of emergency medical services defined in 9 A.A.C. 22, Article 1;
   c. Meets the requirements in A.A.C. R9-22-709 - Contractor's Liability for Hospital for the Provision of Emergency and Subsequent Care; and
   d. Is provided in the most appropriate, cost-effective, and least restrictive setting.
3. Observation days. A contractor may reimburse subcontracting and noncontracting providers for the provision of observation days that do not result in an admission at:
   a. A rate specified by subcontract; or
   b. In the absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered billed charges.
4. Outpatient hospital reimbursement. A contractor shall reimburse subcontracting and noncontracting providers for the provision of outpatient hospital services rendered at either:
   a. A rate specified by subcontract. Subcontract rates, terms, and conditions are subject to review, and approval or disapproval under A.R.S. § 36-2904 and A.A.C. R9-22-715; or

b. In the absence of a subcontract, the AHCCCS hospital-specific outpatient cost-to-charge ratio multiplied by covered billed charges.

5. Out-of-state hospital reimbursement. A contractor shall reimburse an out-of-state hospital for the provision of inpatient and outpatient hospital services at:
   a. The lower of the negotiated discounted rates; or
   b. 80 percent of billed charges.

D. Transfer of payments. The ~~PSA~~ Administration or a contractor shall meet the requirements in A.A.C. R9-22-704.

ARTICLE 8. MEMBERS' RIGHTS AND RESPONSIBILITIES FOR EXPEDITED HEARINGS

R9-30-807. Expedited Hearing Process

A. Request for expedited hearing.
1. If a contractor denies, reduces, suspends, or terminates a service that requires authorization, a member is entitled to an expedited hearing if a member files a request for hearing under the time-frames in subsection (B).
2. A member shall file a request for expedited hearing or a request for expedited hearing and continued services in the same manner as provided in R9-22-803.

B. Time-frames. A member shall file a request for hearing with the Administration or the contractor:
1. No later than 10 business days after the date of personal delivery of the notice to the member; or
2. No later than 15 business days after the postmark date, if mailed, of the notice.

C. Expedited hearing. A hearing under this Section shall be held no sooner than 20 days, and not later than 40 days, after the ~~PSA's~~ Administration's receipt of the request for hearing. The hearing may be held sooner than 20 days after the Administration's receipt of the request for hearing upon the agreement of all of the parties or upon written motion of one of the parties establishing:
1. Extraordinary circumstances, or
2. The possibility of irreparable harm if the hearing is not held sooner.

D. Notice of hearing. The ~~PSA~~ Administration or its designee shall provide notice of the hearing to the member or the authorized representative and to all other parties to the hearing.

E. Continued services. If a request for expedited hearing and a request for continued services is filed in a timely manner under this Section, the contractor shall not terminate, reduce, or suspend the service during the expedited hearing process.

F. Previously authorized service.
1. In addition to services which are continued under subsection (E), the contractor shall continue services pending a hearing decision if:
   a. The contractor denies an authorization for a previously authorized service for the member because the contractor considers the service new and independent of any previous authorization;
   b. The member's primary care physician asserts that the requested service is a necessary continuation of the previous authorization; and
   c. The member challenges the denial on this basis and timely requests continued services.
2. Services shall not be continued if:
   a. The parties reach some other agreement, or
   b. The contractor believes the primary care provider's request endangers the member.

G. Financial liability of a member. A member whose service is continued during the expedited hearing process is financially liable for the service received if the Director upholds the decision to reduce, suspend, or terminate the service.

H. General provisions. If an expedited hearing is requested, a hearing shall be conducted under A.R.S. § 41-1092.

I. Alternative hearing process. A request for expedited hearing shall be considered a grievance under 9 A.A.C. 30, Article 6, and the ~~PSA~~ Administration shall forward the request to the contractor within 10 business days after the day the Administration receives the request if:
1. The Administration determines that a request for hearing filed under this Section is not timely, as determined by the Office of Legal Assistance's date stamp on the document; or
2. The request for hearing does not involve the denial, reduction, suspension, or termination of a service.

ARTICLE 9. CONTRACT PROCESS

R9-30-901. General Provisions

A. Authority. The Administration has full operational authority to award contracts under A.R.S. § 36-2923.01.

B. Requirements. The Administration and qualified providers of health care who have contracts to provide services under the Administration shall conform to the requirements in this Article and A.R.S. § 36-2923.01. A contractor that has contracts and subcontracts entered into under this Article shall have records on file.

C. Insufficient Coverage. If the Director determines there is insufficient coverage in a county, the Director shall attempt to contract with a prepaid capitated provider as defined in A.R.S. § 36-2901, to provide services under the PSP under A.R.S. § 36-2923.01.

D. Contract. If the Administration determines that it is in the best interest of the state, The Administration may cancel or reject a contract in whole or in part, as specified in contract. The Administration shall include the reasons for cancellation or rejection in the contract file.

E. Damages or claims. Offerors shall have no right to damages or basis for any claims against the state, its employees, or agents, as a result of any action by the Administration under the provisions of subsection (B).

R9-30-902. Contract Compliance Sanction

The Director may impose a sanction upon a contractor that violates any provision of the rules as specified in contract and under A.A.C. R9-22-606.

R9-30-903. Contract Protest; Grievance and Request for Hearing

The contractor shall file a grievance under 9 A.A.C. 22, Article 8.